

ESH Coordinators Meeting

Effective Corrective Action Development Subject Area

Presented by Ed Sierra
Occurrence Program Coordinator
Quality Programs & Services Office

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Effective Corrective Action Development Subject Area



OUTLINE

- Purpose
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Why do a Causal Analysis?

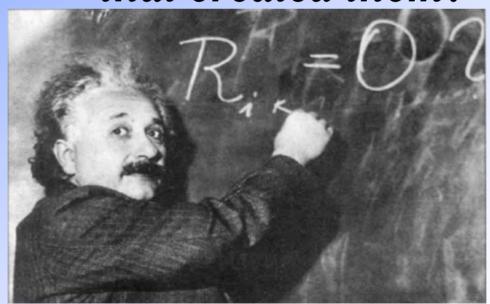
- Promote better corrective actions to prevent recurrence
 Effective corrective actions flow from causes
 - •WE MUST MELT THE ICEBERG





Why do a Causal Analysis? II

"It's impossible to solve significant problems using the same level of knowledge that created them!"





Background

- Owner J. Tarpinian
- Notice of Intent April 01
- Team: Commenced work in July 02
 - Ed Sierra (Team Leader), QP&SO
 - Dave Passarello, CA-D
 - Steve Hoey, SMŚIOJohn Boccio, EENS

 - Stasia Scocca, QP&SO
 - John Usher, IO Office/PAAA
 - Ray Costa, EP
 - Joyce Mortimer (Administrative Support), QP&SO
 Tina Youngmann (Technical Writer), SBMS



Background II

- Point of Contact Team Members Review & Approval:
 - Mike Zarcone, Physics
 - Pat Williams, ÉP
 - Andy Levine, RCD
 - Bill Gunther, Medical
 - Nicole Bernholc, S&HS
- "Overall, this is an impressive subject area that should standardize the manner in which causal analysis and corrective actions are approached across BNL. The subject area is easy to navigate and provides very straight-forward information on causal analysis and corrective action development."

Dr. John Dew, Director for Continuous Quality Improvement - University of Alabama





Drivers

- DOE M 232.1-1A Occurrence Reporting and Processing of Operations Information
 - ORPS Re-design category "Repetitive"
- DOE O 414.1A Quality Assurance
- 10CFR Part 830 Subpart A Quality Assurance
- International Standard ISO 14001
- Mitigation of PAAA civil penalties (50%) for corrective actions that prevent recurrence
- E. I. Du Pont de Nemours and Company Safety Benchmarking Assessment (Feb. 03)
- This SA replaces IO-SOP-11, Conducting Causal Analysis For PAAA Noncompliances, Rev. 1.





Scope

- 1. Selecting Causal Analysis Methodologies
 - Selection guidance (Graded approach)
 - SME's identified
- 2. Implementing Causal Analysis
 - 10 methods available
 - ORPS causal analysis tree (CAT team review)
- 3. Developing Corrective Actions
 - Physical barriers
 - Admin. barriers
 - Management barriers



Causal Analysis Methodologies A Recipe for Effective Corrective Actions

- Low Complexity Level
 - What-if Analysis
 - Five Whys
 - Brainstorming
 - Expert Judgment
- Moderate Complexity Level
 - Barrier Analysis
 - Change Analysis
 - Events & Causal Factors Analysis

- High Complexity Level
 - Fault Tree Analysis
 - Management Oversight and Risk Tree Analysis
 - TapRoot



Causal Delight

1. Defective or failed part

3. Defective weld, braze

or soldering joint

4. End of life failure

2. Defective or failed material

5. Electrical or instrument noise

code.

Rest/sleep LTA.



A5 Training Deficiency A4 Design Problem **A6 Management Problem** A1 Equipment/Material A2 Procedure Problem A3 Personnel Error A8 Radiological/ Hazardous Problem **Problem B1 NO TRAINING B5 POLICY NOT ADE-**B1 INADE-OUATELY DEFINED/ B1 LEGACY **OUATE** 1. Controls LTA 1. Decision not to train CONTAMINA-**ADMINIS-**2. Displays LTA 2. Training requirements **ENFORCED** TRATIVE 1. No SPAC 3. Control/display integration LTA not identified CONTROL 4. Conflicting layouts 2. Communication of B2 SOURCE between shifts & 1. Not strict 5. Reach or visual envelope LTA **B2 TRAINING** SPAC LTA **UNKNOWN** enough 6. Labeling LTA RECORDS SYSTEM LTA 3. Enforcement LTA A7 External 2. Confusing or 7. Housekeeping LTA 1. Training records Phenomena incomplete 8. Climate LTA incorrect **B6 OTHER MANAGE** 4. Verification/repeat back 3. Technical error MENT PROBLEMS 9. Lighting LTA 2. Training records not up B1 WEATHER OR 4. Responsibility 1. Safety review LTA **AMBIENT** for item/activity wrong/incomplete 2. Safety review not 11. Protective clothing **CONDITIONS** 7. Graphics LTA not adequately 12. No communication method **B3 TRAINING LTA** performed 8. Equipment identification 7. Communication within defined available 1. Job/task analysis LTA 3. Safety review recom-B2 POWER FAILURE 5. Contradictory 13. Other environmental stresses 2. Program design LTA mendations not yet OR TRANSIENT 8. Communication requirements 3. Training objectives implemented between shifts LTA 6. Scheduling/ **B2 INADEQUATE OR DEFECTIVE** 4. Corrective action B3 EXTERNAL FIRE tracking system LTA 4. Inadequate content OR EXPLOSION B2 INATTENTION TO LTA 1. Design input cannot be met 5. Insufficient practice or 5. Corrective action not 7. Employee 3. Routine testing program LTA 2. Design input obsolete hands on experience vet implemented B4 THEFT TAMPER-12. Identification of screening LTA 3. Design input not correct 6. Qualifications testing 6. Control of changes to ING SABOTAGE OR revised steps LTA 8. Recently **B3 PROCEDURE NOT** 4. Necessary design input not LTA service procurement **VANDALISM** 13. Typographical error changed **USED OR USED** available 7. Insufficient refresher specifications purchase 14. Sequence wrong 9. Difficult to 1. Material handling LTA **INCORRECTLY** 5. Design output scope LTA training order LTA B5 OTHER NATU-15. Facts wrong/ implement 6. Design output not clear 2. Material storage LTA 8. Training support 7. Service does not meet RAL PHENOMENON 10. Implemen-3. Material packaging LTA **B4 OTHER HUMAN** 7. Design output not correct equipment LTA requirements 16. Incomplete/situation tation of lessons **ERROR** 4. Material shipping LTA 8. Inconsistent design output 9. Instructor qualifications 8. Service acceptance - learned LTA 5. Shelf life exceeded 1. Knowledge-based 9. Design input not addressed in requirements LTA LTA 17. Wrong revision used 9. Control of 6. Unauthorized material decision required design output 10. Training on new work B2 INADEQUATE design/field changes 18. Inconsistency between substitution 2. Excessive control action 10. Design/documentation not complete methods LTA RESOURCE requirements 7. Storage of spare parts LTA _11. Designs/documentation not up to 11. Abnormal events/ LTA requirements - ALLOCATION 8. Error by manufacturer in 3. Unrealistic monitoring emergency training LTA 10. Control of as-built shipping or marking 12. Qualification standard documents LTA requirements 1. Lack of procedure **B3 WORK** 9. Contaminant 4. Excessive mental **B3 INDEPENDENT REVIEW/** LTA 2. Not available or ORGANIZA-VERIFICATION workload 13. Inadequate presenta-B6 PROCUREMENT CONTROL inconvenient for use TION/ 5. Errors not detectable 1. No independent review/verification tion or material 3. Procedure difficult to **PLANNING** 1. Control of changes to 6. Errors not recoverable 2. Incomplete review/verification **DEFICIENCY** procurement specifications/ 7. Personal performance 4. Training & reference 1. No preparation purchase order LTA LTA* B4 DRAWING, SPECIFICATION, procedure 2. Job plan LTA 2. Fabricated item does not meet OR DATA ERROR 3. Instructions to requirements workers LTA 3. Incorrect item received Level A nodes are in Blue. Level B nodes are in Green. Level C nodes are in Magenta. 4. Walk-through 4. Product acceptance require-LTA LTA = Less than adequateSPAC = Standards, policies and administrative controls ments LTA 5. Scheduling LTA ■ B7 DEFECTIVE OR FAILED ORPS cause categories are underlined. ORPS reports require at least one B or C level ORPS cause 6. Worker selection

* Examples include: Sensory/perceptual capabilities LTA, Motor/physical capabilities LTA, Attitude/

psychological profile LTA, Reasoning capabilities LTA, Attention below minimum standards and

BROOKHAVEN NATIONAL LABORATORY

- LTA

B4 INADEOUATE

SUPERVISION

1. No supervision

2 Supervision LTA

Approach

- Graded approach
 - Level of causal analysis/corrective actions commensurate with the problem

Informational Sessions

- **SBMS Steering Committee 5/21**
- ■ESH Coordinators 5/22
- ■OPS Council 5/27
- Quality Reps June
- Building Managers July





Questions

Presentation Wrap-Up

